Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICAL HOSPITAL AT FORT WORTH
750 13TH AVENUE
FORT WORTH TX 76104

Respondent Name
CITY OF FORT WORTH

Carrier's Austin Representative Box
04

MFDR Tracking Number
M4-09-5492-01

MFDR Date Received
JANUARY 21, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Not paid according to MAR"

Amount in Dispute: $37,367.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed are copies of the explanation of benefits indicating the implants were correctly denied, as the required certification statement was not included in the documentation. Since the provider has not submitted the required certification statement required by law, no reimbursement is due."

Response Submitted by: Argus Services Corp., 9101 LBJ Freeway, Suite 600, Dallas, TX 75243

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2008 Through June 21, 2008	Inpatient Hospital Surgical Services	$37,367.00	$3,612.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable

reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

5. 28 Texas Administrative Code §134.404(g)(1) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   (1) A facility or surgical provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 5, 2008
   - 16L — Claim/service lacks information which is needed for adjudication. Implants require statement of certification.

   Explanation of benefits dated October 27, 2008
   - 193 — Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 16L — Claim/service lacks information which is needed for adjudication. Implants require statement of certification.

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)(1)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. 28 Texas Administrative Code §134.404(g)(1) states in pertinent part that, "A facility or surgical provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." The Carrier asserts that reimbursement was not recommended for the disputed implantables, as the provider did not submit the billing certification statement as required under DWC rule 134.404 (g)(1). Review of the submitted documentation submitted for medical fee dispute resolution, finds the requestor did not submit documentation to support that the carrier received the required billing certification as required under DWC rule 134.404 (g)(1).

3. Reimbursement for the disputed services is calculated in accordance with 28 Texas Administrative Code §134.404(f)(1)(A) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 473 (per Box 71 on UB-92) is $10,323.21. This amount multiplied by 143% is $14,762.19. The total maximum allowable reimbursement (MAR) is therefore $14,762.19. The respondent previously paid $11,149.67, therefore an additional amount of $3,612.52 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,612.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,612.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 4, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		October 4, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.